STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295050	A. BUILDING _____ B. WING _____	02/29/2008

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LIFE CARE CENTER OF RENO	445 W. HOLCOMB LANE RENO, NV 89511

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification conducted at your facility on 2/25/08 through 2/29/08. The census at the time of the survey was 174. The sample size was 28. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.	F 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Machelle Harris — TITLE: Executive Director — (X6) DATE: 3/21/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that allegations involving mistreatment and abuse for 1 out of 28 residents were reported to the appropriate state agencies as required. (Resident #5) Findings include: Resident #5: The resident was admitted to the facility on 12/22/07, diagnoses included difficulty in walking, general muscle weakness, dysphagia, dementia without behavior disturbance, hypertension, aortic valve disorder, heart valve replacement, chronic obstructive pulmonary disease, osteoporosis, anemia, dizziness, and insomnia On 2/27/08 at 2:40 PM, resident #5 and the resident's son were interviewed. The resident	F 225	**F 225** I) On 1/11/08, the allegation voiced by Resident #5 was investigated. The CNA involved in the alleged rough treatment received counseling, was in-serviced, and wrote an essay assignment. The CNA apologized to Resident #5 and the apology was accepted. No further episodes of rough treatment were voiced. II) Review of past incidents of allegations of abuse indicates no other episodes that were not reported to appropriate state agencies. III) Allegations of abuse will be reported to appropriate state agencies within 24 hours with follow up report of investigation within five business days, which will include investigation findings and corrective actions taken. DON and ED will audit incident reports weekly to ensure allegations of mistreatment and abuse are reported to the state agencies as required. IV) PI Committee to review audits to ensure proper reporting of allegations of abuse to appropriate state agencies until threshold is met (see exhibit #1). V) Director of Nursing, ultimately Executive Director VI) April 15, 2008	

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F 225	Continued From page 2 stated she had some experience with one certified nursing assistant (CNA)who had been verbally rude and treated her roughly while being assisted to the bathroom and being assisted for bed in the evenings. The resident's son stated, his mother had mentioned this incident to him and that his mother's roommate had also told him she had observed the CNA being rude to his mother and treating her roughly. The resident's son stated, this had happened a while back, and they had reported the incident to nursing. The resident's son described the CNA and specifically mentioned that the CNA avoided eye contact with him when he came in to visit. The resident referred to the CNA by first name. They also confirmed that this same CNA was still providing services to the resident. They stated that she was no longer rough with Resident #5. On 2/29/08 at 10:10 AM, in interview, Resident #5's roommate, who was alert and oriented, stated she had witnessed a CNA being rude, short and rushing Resident #5 more than once. The roommate stated the same CNA had also been rude to her once, but she had not reported the incident. On 2/28/08 at 9:20 AM, in a discussion of these allegations, the director of nursing (DON) stated she recalled an incident involving resident #5 in which she had followed up on with a staff member which involved a written warning issued, inservice and paper/write-up (essay) assignment. The DON stated she had not reported the allegations of abuse and mistreatment of resident #5 to the required state agencies.	F 225		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social	F 250		

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F 250	Continued From page 3 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to arrange for medically related social services for 1 of 28 residents (Resident #9) and failed to initiate timely social service care plans for 1 of 28 residents. (Resident #1) Findings include: Resident #9: The 99 year old resident was admitted to the facility on 7/2/07, with diagnoses including congestive heart failure, previous myocardial infarction, renal disease, hypertension, anemia, arthropathy, and urinary retention. The resident transferred to the facility from a small assisted living facility in another state. On admission the resident indicated that she didn't really know why she was not happy in the facility. The resident was admitted with a indwelling catheter and was ambulatory with a walker. The resident refused to participate in answering questions on the social services assessment. The social assessment indicated the lady as "not being very social and having a very negative attitude". In September of 2007, the physician ordered the catheter removed and scheduled a urology consult. The resident refused to allow the catheter removal and signed a waiver for the catheter. The physician canceled the consult and	F 250	**F 250** I) Medically related Social services have been provided as evidenced by the psychiatric consult, which was conducted on 2/27/08. Resident #10's care plan has been amended to address psychosocial preference (see exhibit #2). (The 2567 refers to Resident #9; however the resident described corresponds with Resident #10.) A care plan has been initiated for Resident #1 to address behaviors (See exhibit #3). II) Resident records will be audited based on the score of Geriatric Depression Scale (see exhibit #4) and MDS assessments to ensure that appropriate medically related social services are provided. Resident records will be audited to ensure that residents with behaviors have appropriate care plans in place. III) A Geriatric Depression Scale will be completed upon admission. If depression is indicated on the scale, a referral will be submitted to Social Services to follow up with care planning and interventions. Social Services will monitor moods and behaviors on admission and quarterly through the MDS assessment process.	

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F 250	Continued From page 4 catheter removal. According to the nurses notes of 12/14/07 and 12/21/07, the resident was continent of bowel, gets up to do activities of daily living with minimum assistance and prefers to stay in bed. The resident prefers to stay in her room and watch TV. The nurses notes of 11/21/07, indicated the resident self-isolates in her room and sometimes refuses to shower. The resident did not participate in any group activities and took all meals in her room. The nurses notes of 2/8/08, indicated the resident will not participate in socializing with others and has a poor appetite. The nurses notes of 1/25/08, indicated the resident "can be demanding and argumentative with staff and likes to have everything perfect in her room". Also in the record was documentation that the resident became upset with her roommates family visits in October of 2007, and the roommate asked to be moved and indicated the resident was demanding, hostile and yelled at the roommate's son. Social service notes from that time indicated the social worker contacted Resident #9's grandson and indicated the need for a private room as the resident's TV was disturbing her roommate. The interdisciplinary comprehensive assessment of 10/18/07, indicated the resident appears hostile and angry much of the time. The social services assessment of 10/12/07, titled Psychosocial Well-being indicated the resident had not had a good relationship with any of her	F 250	Nursing staff to be in-serviced in regards to noting new behaviors on the 24 hour report for interdisciplinary review and social service follow up (see exhibit #5). Social Services have been in-serviced regarding timely care plans for residents with moods and behaviors (see exhibit #6). IV) Social Services will perform a random audit monthly to ensure that residents who trigger for mood and behaviors are receiving medically related social services and that mood and behavior care plans are completed (see exhibit #7). Audit results to be reported to the Performance Improvement Committee monthly until threshold is met (see exhibit #8). V) Social Services Director VI) April 15, 2008	

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F 250	Continued From page 5 roommates thus far, and "appears resident's hostility difficult to deal with." A conversation with the social worker on 2/26/08, revealed that the resident had not been evaluated by psychiatrist nor had the social worker considered referring the resident for an evaluation. A psychiatric evaluation was conducted on 2/27/08. Resident#1: The resident was admitted to the facility on 1/08/08. He had been admitted and discharged previously. Diagnoses included muscle weakness, bilateral amputations above the knees, osteomyelitis, diabetes, type II, hypertension, anemia, congestive heart failure and peripheral vascular disease. In an interview with the minimum data set (MDS), nurse #1 on 2/25/08 at 1:15 P.M., it was revealed that the facility social workers were responsible for care planning for moods, cognitive status, behaviors and some psychotropic medication use. Resident #1's MDS completed on 1/31/08 noted in section E4 (behavioral symptoms) that he exhibited verbally abusive behaviors and that he was resistive to care. Documentation in the nurses notes supported that at times, Resident #1 refused care and medications. A copy of Resident #1's social services care plan was requested. No care plan, developed by social services to address these issues, could be located. On 2/25/08 in interview the social worker responsible for Resident #1 stated that she was surprised that there was no social service care plan in the record for the behaviors stated above.	F 250		

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review, it was determined that the facility failed to ensure that 1 of 28 residents received appropriate treatment and services necessary to restore as much normal bladder function as possible. (Resident #1) Findings include: Resident#1: The resident was admitted to the facility on 1/08/08. He had been admitted and discharged previously. Diagnoses included muscle weakness, bilateral amputations above the knees, osteomyelitis, Diabetes, type II, hypertension, anemia, congestive heart failure and peripheral vascular disease. He had a indwelling catheter in place upon admission. Review of the record revealed that on 1/21/08, a physician's order was written to discontinue the resident's catheter and to obtain post voiding residual bladder scans. If the scans revealed over 400 Cubic centimeters (ccs), a straight (one-time), catheterization was to be done.	F 315	**F 315** I: Resident #1's B&B status has been reassessed the care plan has been updated to reflect current status and interventions (See exhibit #9). II: Restorative Nurse will assess current residents with incontinence issues to validate accurate assessment and care plan. Care plans will be modified to reflect changes in care as needed. III: In-service nursing staff regarding the following policy and expected changes: "Incontinence Management Program," documentation of Post Void Residuals on the Treatment Administration Record, and notifying the Restorative Nurse each time a catheter is discontinued (see exhibit #5). Restorative nurse will be responsible for reviewing residents weekly for evaluation of effectiveness of current program and revisions as needed. The Bowel and Bladder Scheduled Toileting Program Form has been revised for effective weekly documentation (see exhibit #10). IV: Restorative Nurse or designee will conduct random weekly audits of incontinence care, incontinence management program, B&B assessment, and B&B care planning	

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F 315	Continued From page 7 Review of the record showed no evidence that the post voiding scans were being done. The restorative nurse confirmed that the scans could not be located. He stated that he was not aware if the scans had been completed as ordered . Additional review of the record confirmed that the catheter for Resident #1 was not discontinued until 5:00 PM on 1/25/08. The restorative nurse could not explain the delay in carrying out the order. An assessment for Bowel and Bladder (B&B) Training was completed following the resident's admission while the catheter was still in place. Another assessment was completed following the removal of the catheter. That assessment, completed 1/24/08, indicated that based on the score, the resident was a good candidate for toileting, timed or scheduled voiding. Review of the documentation on the Bowel and Bladder Schedule Program indicated that the resident was then toileted every two hours from 1/24-1/28/08. An undated comment on the form stated that "he was still having moderate episodes of bladder incontinence" and that the plan was to increase the schedule to approximately every hour. An additional record dated 1/29-1/31/08 indicated that the resident had continued to be toileted every 2 hours from 6:00 AM until 8:00 PM, and then not again until 4 hours later. There was no comment or analysis for this data. Review of the Urinary Incontinence Questionnaire contained in the record revealed it was incomplete and not signed by the person doing the assessment. Review of the MDS completed on 1/31/08 showed that the resident was	F 315	(see exhibit #11). Performance Improvement Committee will review monthly until threshold is met (see exhibit #12). V: Restorative Nurse, ultimately Director of Nurses VI: April 15, 2008	

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F 315	Continued From page 8 occasionally incontinent of urine (2 or more times a week but not daily) and was on a scheduled toileting LPN #1 indicated during an interview on 2/28/08 that a new form for documenting the bladder schedule had been introduced. The new form, dated 2/1-2/15/08, for Resident #1 did not demonstrate any specific pattern of toileting or incontinence, but a comment dated 2/7/08 stated that the pattern would continue to be observed for one more week. An additional comment recorded on 2/15/08 stated that Resident #1 continued to have episodes of incontinence despite an increase in scheduling and that now the scheduled toileting would be discontinued. Although incontinence was included in the care plan addressing the risk of skin breakdown, no dedicated care plan for urinary incontinence could be located in the record. The specific approaches for skin breakdown were to refer to restorative assistance (RA) for a B&B program and prompted voiding every 2-3 hours. LPN #1 did locate outside of the record, an interim care plan developed prior to the MDS, that addressed incontinency with the approach of prompting hourly. When staff was asked how the specifics of the toileting schedule and program were conveyed to the CNA's, it was stated that the information was in the care plan and was also passed on in report. LPN #1 stated that he analyzed the data and made recommendations about every two weeks. Review of the facility policy, Incontinence Management Program, revealed that scheduled toileting involved assisting the resident in toileting	F 315		

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F 315	Continued From page 9 at fixed intervals whether he indicated a desire to go or not. Prompted voiding involved regularly offering the resident the opportunity to toilet but only toileting if he desired so. There was no evidence showing whether Resident #1 was on a scheduled toileting program or a prompted voiding program. The assessment indicated that he was to be on a scheduled toileting program. The skin breakdown care plan indicated prompted voidings. The policy further stated that the training coordinator would initiate the care plan for (bladder) retraining that would include goals and training interventions. Other points in the policy included instruction on the use of the call system, avoiding briefs or other incontinence products, therapy referrals for strengthening, transfers and clothing management, an adequate fluid intake and a carefully set schedule of elimination times. The policy also stated that the RA coordinator would complete weekly progress notes, review/adjust goals and update the care plan. There was no evidence that a complete and comprehensive care plan had been developed or that a definite program was consistently followed for Resident #1. As of 2/15/08, Resident #1 was no longer on a scheduled toileting program and continued to be incontinent of urine.	F 315		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to transport food under sanitary conditions for all residents who dined in the main dining room. Findings include: On 2/28/08, at 12:30 PM, food was observed being transported from the kitchen to the main dining room on an open cart. The trays of food contained the chicken entree, the rice, the vegetables, and the pureed food to be placed in the steam table in the dining room. The trays of food were not covered as they were transported from the kitchen to the dining room. At approximately 1:25 PM, it was observed that the cook covered the food with foil before it was transported back to the kitchen. On 2/28/08, at 12:45 PM, in interview, the cook stated that most of the time the food would be covered while it was transported from the kitchen to the dining room. She said that today she was in a hurry, and did not cover the food before it left the kitchen. On 2/28/08, at 2:00 PM, in interview, the Director of Food services stated that the food should have been covered for transport prior to leaving the kitchen.	F 371	**F 371** I: Currently, food is transported to the main dining room following sanitary conditions. II: Dietary Manager or designee will monitor food being transported from the kitchen to ensure transportation of food under sanitary conditions. III: In-service dietary staff regarding food transporting protocol (see exhibit #13). IV: Dietary Manager or designee to audit food transporting techniques weekly to ensure that protocol is followed (see exhibit #14). Results of audits will be reported to Performance Improvement Committee on a monthly basis until threshold is met (see exhibit #15). V: Dietary Manager VI: April 15, 2008	
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		

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F 431	Continued From page 11 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that all drugs and biologicals were either properly labeled or disposed of to ensure resident health and safety. Findings included:	F 431	**F 431** I: The Lorazepam and IV solutions have been discarded as appropriate. II: Review of Medication Rooms and Medication Carts by Resident Care Managers. III: Nursing staff will be educated regarding proper labeling, dating vials upon opening, and timely disposal of medications to ensure resident health and safety (exhibit #5). Resident Care Managers or designee to do weekly compliance audits of medication rooms and carts to ensure compliance (see exhibit #16). Pharmacy Consultant to conduct random audits. IV: Audit findings to be reported to Performance Improvement Committee on a monthly basis until threshold is reached (see exhibit #17). V: Resident Care Managers, ultimately Director of Nurses. VI: April 15, 2008	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295050	A. BUILDING _____ B. WING _____	02/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RENO	445 W. HOLCOMB LANE RENO, NV 89511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 On 2/26/08 observation of the medication room on 400 Hall of the Denton Building revealed that located in the locked refrigerator was a vial of Lorazepam, which was opened, but not dated as of the day it was opened. Also in this room, the medication refrigerator contained three bags of Vancomycin 1300 mg in 250 cc of normal saline. The labels on the bags directed that the bags were to have been discarded on 2/20/08.	F 431	**F 441** I) The facility has a system in place to identify, track, and record residents placed in isolation. II) Facility will review physician's orders and conduct physical rounds to identify residents in isolation.	
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined that the facility failed to maintain a system that identified and recorded information regarding residents placed in isolation for infection. Findings included: On 2/28/08, during interview the infection control nurse #1 (,in reviewing the Infection Control records), found that while infections occurring in the facility were identified and logged, there was no system for tracking residents placed in	F 441	III) Infection Control Nurse has been educated (see exhibit #18) regarding the implementation of the facility's infection control tracking software already in place, which includes residents in isolation for infection (type, organism, appropriate antibiotic, outcome, and date discontinued). IV) Director of Nurses or designee to conduct weekly audit of infection control log to validate identification of residents with isolation precautions (see exhibit #19). Infection Control tracking logs to be maintained in Infection Control Binder and submitted to Performance Improvement Committee monthly (see exhibit #20). V) Infection Control Nurse, ultimately Director of Nurses. VI) April 15, 2008	

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F 441	Continued From page 13 isolation for infection. Such a system would identify the resident, the type of isolation, the organism responsible for the infection, if the antibiotic was appropriate for the identified organism, the outcome of the treatment and the date the isolation was discontinued.	F 441		